

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly
Press Hard

STUDENT ID NUMBER
OSIS

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TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address			Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other
City/Borough	State	Zip Code	School/Center/Camp Name	District Number
Health insurance (including Medicaid)? <input type="checkbox"/> Yes <input type="checkbox"/> No		Parent/Guardian Last Name		First Name
		Foster Parent		Phone Numbers Home Cell Work

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____ Allergies <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____	Does the child/adolescent have a past or present medical history of the following? Asthma (check severity and attach MAF/Asthma Action Plan): <input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <i>If persistent, check all current medication(s):</i> <input type="checkbox"/> Inhaled corticosteroid <input type="checkbox"/> Other controller <input type="checkbox"/> Quick relief med <input type="checkbox"/> Oral steroid <input type="checkbox"/> None <input type="checkbox"/> Attention Deficit Hyperactivity Disorder <input type="checkbox"/> Orthopedic injury/disability <input type="checkbox"/> Chronic or recurrent otitis media <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Other (specify) _____	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____ Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____
<i>Explain all checked items above or on addendum</i>		

PHYSICAL EXAMINATION Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	General Appearance: <table border="0"> <tr> <td><i>Nl Abnl</i></td> <td><input type="checkbox"/> HEENT</td> <td><i>Nl Abnl</i></td> <td><input type="checkbox"/> Lymph nodes</td> <td><i>Nl Abnl</i></td> <td><input type="checkbox"/> Abdomen</td> <td><i>Nl Abnl</i></td> <td><input type="checkbox"/> Skin</td> <td><i>Nl Abnl</i></td> <td><input type="checkbox"/> Psychosocial Development</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> DENTAL</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Lungs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Genitourinary</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neurological</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Language</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Cardiovascular</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Extremities</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Back/spine</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/> Behavioral</td> </tr> </table> Describe abnormalities: _____ _____	<i>Nl Abnl</i>	<input type="checkbox"/> HEENT	<i>Nl Abnl</i>	<input type="checkbox"/> Lymph nodes	<i>Nl Abnl</i>	<input type="checkbox"/> Abdomen	<i>Nl Abnl</i>	<input type="checkbox"/> Skin	<i>Nl Abnl</i>	<input type="checkbox"/> Psychosocial Development	<input type="checkbox"/>	<input type="checkbox"/> DENTAL	<input type="checkbox"/>	<input type="checkbox"/> Lungs	<input type="checkbox"/>	<input type="checkbox"/> Genitourinary	<input type="checkbox"/>	<input type="checkbox"/> Neurological	<input type="checkbox"/>	<input type="checkbox"/> Language	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/> Extremities	<input type="checkbox"/>	<input type="checkbox"/> Back/spine	<input type="checkbox"/>	<input type="checkbox"/> Behavioral
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DEVELOPMENTAL (age 0-6 yrs) <input type="checkbox"/> Within normal limits If delay suspected, specify below <input type="checkbox"/> Cognitive (e.g., play skills) _____ <input type="checkbox"/> Communication/Language _____ <input type="checkbox"/> Social/Emotional _____ <input type="checkbox"/> Adaptive/Self-Help _____ <input type="checkbox"/> Motor _____	SCREENING TESTS <table border="1"> <thead> <tr> <th></th> <th>Date Done</th> <th>Results</th> </tr> </thead> <tbody> <tr> <td>Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)</td> <td>____/____/____</td> <td>_____ µg/dL</td> </tr> <tr> <td>Lead Risk Assessment (annually, age 6 mo-6 yrs)</td> <td>____/____/____</td> <td><input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk</td> </tr> <tr> <td>Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE</td> <td>____/____/____</td> <td><input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</td> </tr> <tr> <td>Hemoglobin or Hematocrit (age 9-12 mo)</td> <td>____/____/____</td> <td>_____ g/dL _____ %</td> </tr> </tbody> </table>		Date Done	Results	Blood Lead Level (BLL) (required at age 1 yr and 2 yrs and for those at risk)	____/____/____	_____ µg/dL	Lead Risk Assessment (annually, age 6 mo-6 yrs)	____/____/____	<input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	Hearing <input type="checkbox"/> Pure tone audiometry <input type="checkbox"/> OAE	____/____/____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Hemoglobin or Hematocrit (age 9-12 mo)	____/____/____	_____ g/dL _____ %	Tuberculosis <i>Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school</i> PPD/Mantoux placed: ____/____/____ Induration _____ mm PPD/Mantoux read: ____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Interferon Test: ____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos Chest x-ray (if PPD or Interferon positive): ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Not Indicated <input type="checkbox"/> Abnl
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	Head Start Only	Vision <i>(required for new school entrants and children age 4-7 yrs)</i> ____/____/____ <input type="checkbox"/> with glasses Acuity Right ____ / ____ Left ____ / ____ Strabismus <input type="checkbox"/> No <input type="checkbox"/> Yes															

IMMUNIZATIONS - DATES CIR Number of Child: _____ Hep B ____/____/____ Rotavirus ____/____/____ DTP/DTaP/DT ____/____/____ Hib ____/____/____ PCV ____/____/____ Polio ____/____/____	Influenza ____/____/____ MMR ____/____/____ Varicella ____/____/____ Td ____/____/____ Tdap ____/____/____ Hep A ____/____/____ Meningococcal ____/____/____ HPV ____/____/____ Other, Specify: _____; _____
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RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Full diet <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____	ASSESSMENT <input type="checkbox"/> Well Child (V20.2) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-9 Code _____ _____ _____
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Health Care Provider Signature	Date ____/____/____	DOHMH PROVIDER ONLY PROVIDER I.D. _____
Health Care Provider Name and Degree (print)	Provider License No. and State	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s)
Facility Name	National Provider Identifier (NPI)	Comments
Address	City	Date Reviewed: ____/____/____
Telephone (____) _____-____	Fax (____) _____-____	I.D. NUMBER _____
		REVIEWER: _____